to the final determinations on all facility appeals statewide submitted in accordance with this subparagraph.

(iii) The case mix adjustment percentage determined pursuant to this paragraph shall be prospectively applied and subsequently reconciled upon the conclusion of the appeal process as identified in subparagraph (ii) of this paragraph.

(2) If in any quarter of the rate year the estimated allowable non-Medicare cumulative case mix increase for the rate year exceeds the maximum allowable statewide increase, case payment rates made to general hospitals by governmental payors, corporations operating in accordance with Article 43 of the Insurance Law and organizations operating in accordance with Article 44 of the Public Health Law shall be adjusted downward [on the basis of a statistical methodology that shall consider, but not be limited to, past trends in changes in case mix, changes in the hospital's service delivery, and referral patterns. This adjustment may be made to reflect the anticipated increase in case mix index in the rate year which shall be reconciled to the actual case mix increase and prospectively adjusted in a future rate period. Such adjustment shall be made under] based on the same methodology as contained in paragraph (1) of this subdivision.

(3) [A hospital may appeal the determination of its allowable cumulative case mix increase for the rate yeark pursuant to the provisions of section 86-1.61 of this Subpart.] The Commissioner shall, based on the same methodology as contained in paragraph (1) of this subdivision, periodically prospectively adjust downward case payment rates made to general hospitals by government payors, corporations operating in accordance with Article 43 of the Insurance Law and organizations operating in accordance with Article 44 of the Public Health Law to account for increases in the estimated allowable non-Medicare cumulative case mix increase for the rate year which exceeds the maximum allowable state wide increase. This adjustment may be made to reflect the anticipated increase in case mix index in the rate year which shall be reconciled to the actual case mix increase and prospectively adjusted in a future rate period.

(4) Not withstanding any inconsistent provision of this subdivision, for the period beginning on or after July 1, 1990 and ending on December 31, 1990 the commissioner shall reduce, in accordance with the methodology adopted for purposes of adjustments pursuant to paragraph (2) of this subdivision, for purposes of payments on an interim basis, individual general hospitals' case payment rates applicable to state governmental agencies for a prospective period to reflect an estimate of the cumulative increase in statewide average assignment to diagnosis-related groups for prior periods including prior quarters of the rate period which exceeds the allowable statewide increase specified in paragraph (1) of this subdivision for the prospective period. Such adjustment if effected for less than an annual prospective rate period shall reflect an annualized adjustment.

86-1.61 Adjustments to case based and exempt unit rates of payment. The Commissioner of Health shall consider only those applications for adjustments to established rates of payments in the rate year which are in writing and have one or more of the following bases.

(a) Mathematical or clerical errors in the cost and/or statistical data originally submitted by the medical facility, including information reported on the ~~{uniform bills (UBFs) and discharge data abstracts (DDAs)}~~ universal data set (UDS), or revisions initiated by an article 43 corporation or by the sponsor government of a governmental facility, or mathematical or clerical errors made by the Department of Health or an article 43 corporation. Revised data submitted by a facility must meet the same certification requirements as the original data and the commissioner may require verification of revised ~~{UBF and DDA}~~ UDS data by an independent review agent at the cost of the facility. Appeals pursuant to this subdivision must be submitted within 120 days of receipt of the applicable title XIX and/or article 43 corporation initial rate computation sheet. Section 86-1.16 of this Subpart shall apply to appeals not commenced within such time.

(b) Adjustments to established case-based rates of payment developed pursuant to section 86-1.54 (a)-(b) of this Subpart, to reflect additional inpatient operation expenses related to construction or service changes of a hospital that exceed seven and one-half percent of the hospital's reimbursable historical inpatient operational expenses after application of the trend factor. The determination of net incremental costs shall be made in accordance with section 86-1.17(a)(4)(ii)(a) of this Subpart and the following:

(1) projected discharges shall be applied as the denominator to the base year reimbursable costs, subject to the provisions of paragraph (3) of this subdivision;

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(2) a revised rate shall be calculated by adding the rate based on the revised base year costs as determined in paragraph (1) of this subdivision and the net incremental cost add-on for the approved CON project. The net incremental cost add-on portion of the revised rate shall be determined by dividing the approved budgeted CON project costs by rate year discharges. The

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facility's group shall be established pursuant to section 86-1.54 of this Subpart;

(3) upon receipt of actual cost data or audit reconciliation, the amount of reimbursement shall be the lesser of actual or approved incremental operating costs for every approved appeal. Overpayments determined upon audit or based on actual costs shall be recouped pursuant to this Subpart; and

(4) the calculation of an incremental add-on shall be limited to the initial year of project implementation and the first full calendar year of project operation after the year of initial implementation. For subsequent years, the incremental add-on shall be calculated based on the provider's first full calendar year approved incremental costs trended, less the provider's initial year incremental costs, also trended, if included in the base year used to calculate the prospective rate for which a rate revision is being requested. Rate revisions in subsequent years may be made until the costs of the first full calendar year of project operation are reflected in the base year upon which the prospective rate is being determined. An appeal [may be submitted] pursuant to this subdivision must be submitted [at any time throughout] on or before the sixtieth day after the end of the rate period. Any modified rate certified pursuant to this [paragraph] subdivision shall be effective [the first day of the month following 30 days after receipt of the appeal request and justification;] as of the date such allowable costs are incurred or required approvals are obtained, whichever is later.

(c) Adjustments to the average reimbursable inpatient operational cost per diem of an established rate of payment for exempt hospitals or units to reflect additional inpatient operational expenses

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(d) Documented increases in the operating costs of a hospital, not included in payment rates, resulting from the implementation of additional staff or services specifically mandated for the facility by the commissioner. An appeal pursuant to this subdivision must be submitted on or before the sixtieth day after the end of the rate period. Any modified rate certified pursuant to this subdivision shall be based upon actual allowable cost, which data must be submitted by the hospital within 60 days of the end of the rate period, and shall be effective the date additional staff not reflected in the base year is hired by the facility and/or when such allowable costs are incurred or required approvals are obtained, whichever is later.

(e) The reduction of costs related to the elimination of a general hospital inpatient service or identifiable unit of such a service in instances in which the costs of such service were included in the rate established. An appeal pursuant to this subdivision must be submitted on or before the sixtieth day after the end of the rate period. Any modified rate certified pursuant to this subdivision shall be effective as of the date of elimination of the service or unit and shall be subject to the provisions of section 86-1.31.

(f) Additional costs incurred in meeting state and federal requirements. An appeal pursuant to this subdivision must be submitted on or before the sixtieth day after the end of the rate period. Any modified rate certified pursuant to this subdivision shall be effective as of the date of compliance with the requirement.

(g) Additional operating costs incurred to permit a more efficient and economical method of delivering a service. An appeal pursuant to this subdivision must be submitted on or before the sixtieth day after the end of the rate period. Any modified rate certified pursuant to this

subdivision shall be effective as of the date that the additional allowable costs are incurred.

(h) Increased costs determined to be needed to recruit or maintain an appropriate level of personnel providing professional services to patients. An appeal pursuant to this subdivision must be submitted on or before the sixtieth day after the end of the rate period. Any modified rate certified pursuant to this subdivision shall be effective as of the date that the additional allowable costs are incurred.

(i) The designation of the hospital's group pursuant to the provisions of section 86-1.54(b) of this Subpart. An appeal pursuant to this subdivision must be submitted within 120 days of receipt of the applicable title XIX and/or article 43 corporation initial rate computation sheet. Any modified rate certified pursuant to this subdivision shall be effective the first day of the rate period.

(j) Increased costs for compensation of employees. An appeal pursuant to this subdivision must be submitted on or before the sixtieth day after the end of the rate period. Any modified rate certified pursuant to this subdivision shall be effective as of the date the allowable increased costs are incurred.

(k) for exempt hospitals and units [~~that are not inpatient exempt psychiatric units receiving payment pursuant to section 86-1.57(c)(1) of this Subpart,~~] volume adjustment appeals may be made pursuant to the provisions of section 86-1.64(a) of this Subpart. An appeal pursuant to this section must be submitted within 120 days of receipt of the initial volume adjusted rate computation sheet. Any modified rate certified pursuant to this subdivision shall be effective the first day of the rate period.

(l) Adjustments to rates made pursuant to this section shall be ...ade prospectively, [however,] based on the methodology for the calculation of rates of payment for such prospective rate period, provided, however, that no recalculation of bad debt and charity care allowance percentages determined in accordance with section 86-1.65 shall be made for a prospective adjustment which reflects the retroactive impact of an adjustment. [adjustments] Adjustments to rates to reflect 1987 data and statistics may be made retrospectively and such retrospective adjustments shall, to the extent practicable, be cumulated for one comprehensive adjustment. This comprehensive adjustment must be appealed within 120 days of receipt by the facility of the notice of such revised rates.

(m) Hospitals may appeal the determination of allowable cumulative increases in case mix for the rate year pursuant to section 86-1.60 of this Subpart based on such factors as changes in hospital service delivery referral patterns. An appeal pursuant to this section must be submitted within 90 days of receipt of notice of such determination and any modified rate certified pursuant to this subdivision shall be effective as of the date of the case mix adjustment.

(n) The appeal process shall be in accordance with section 86-1.17(c), (e) and (f) of this Subpart, provided, however, that documentation sufficient to support such appeal, including verifiable costs and statistics, must accompany every appeal. Letters of intent to appeal or appeal packages lacking such documentation shall not be accepted or considered to be an appeal.

86-1.62 Service intensity weights and group average arithmetic inlier lengths of stay. (a) The following table provides the relative cost weight or service intensity weight (SIW) and the group average arithmetic inlier length of stay (LOS) for each DRG that are used in the calculation of rates of payment pursuant to this Subpart. The calculation of SIWs shall be determined using [~~1989~~] 1992 costs and statistics from a sample of New York State hospitals, excluding all costs associated with Medicare patients, secondary payor payments made on behalf of Medicare patients, alternate level of care patients, exempt units, hospital medical malpractice insurance, transfer patients (other than those in DRGs specifically identified as transfer DRGs), hospital-specific services, direct and indirect GME, short stay patients and the outlier portion only of the days and costs of high stay and high cost outliers.

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